of all dressing changes were performed by nurses or auxiliary nurses in primary health care or home health care. Surgical procedures (pinch graft, skin grafting, venous vascular surgery) had been undertaken in 22% of the patients. The average weekly cost was €114, though it differed depending by ulcer size. For ulcers <10 cm^2 the weekly cost was €73, while the cost for larger ulcers was €179. The total direct annual costs for leg ulcers in Sweden could be estimated at €180 million (2002 prices) based on a point prevalence of 0.3%. **CONCLUSIONS:** Treatment of leg ulcers seems to have improved compared with previous reports, resulting in slightly decreased costs. Nevertheless, the costs are still substantial and the management of these patients requires large resources. Further development including a more structured management, more careful selection of dressing products and decreased frequency of dressing changes could be encouraged. Such changes could imply further improvements in wound healing and quality of life for patients and decreased costs for the health care system and for society.

PHL7

COST OF TREATMENT (COT) FOR VENOUS LEG ULCERS IN SWEDEN AND THE UK—ESTIMATES FROM CLINICAL EXPERT PANELS AND MODEL SIMULATIONS

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OBJECTIVES: The aim of the study was to estimate the costs of treating venous leg ulcers (VLU) in Sweden and the UK and to compare and discuss possible differences between the two countries. **METHODS:** Costs for VLU treatment were estimated with a health economic model based on resource use data obtained from prospectively collected patient data, expert panels in Sweden and the UK, and scientific publications. The model simulated costs for healing of an initial ulcer, costs for prevention of new ulcers in an ulcer free period, and costs of treating second ulcers for a period of one year. Simulations were performed for ulcers of durations <6 months or >=6 months and sizes <10 cm^2 or >=10 cm^2. **RESULTS:** For an initial ulcer with a duration >=6 months and a size >=10 cm^2 the mean total treatment costs were €2295 in Sweden and €1994 in the UK. Costs of prevention in the ulcer-free period were €127 in Sweden and €45 in the UK. Total costs for one year were €2797 in Sweden and €2138 in the UK. Labour accounted for most of the costs in both countries, while costs of dressings and other material were about 14% for the initial ulcer in Sweden and 21% in the UK. Costs of surgical procedures were low in both countries. Treatment costs decreased in patients with shorter ulcer duration and smaller ulcer size. Nevertheless, the difference in costs between the countries remained in all groups. **CONCLUSIONS:** The most important factor influencing treatment costs in the two countries is the frequency of dressing changes resulting in higher cost of treatment of VLU in Sweden. Other differences of importance are the organisation of treatment and management of VLU.

PHL8

COST-EFFECTIVENESS OF PATHOGEN INACTIVATION VIA THE INTERCEPT BLOOD SYSTEM FOR PLATELETS IN SPAIN

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OBJECTIVE: The residual risk of transmitting infectious blood-borne pathogens via blood transfusion persists despite recent blood safety advances. The INTERCEPT Blood System (IBS) for platelets has been developed to further reduce these pathogen transmission risks during platelet transfusions. The objective of this study was to assess the cost-effectiveness of using random-donor platelets (RDP) and single-donor platelets (SDP) processed with IBS in Spain. **METHODS:** A literature-based decision analysis model was used to assess the cost-effectiveness of the IBS in four patient populations that account for most of the platelet usage in Spain: 1) a 10-year-old male with acute lymphocytic leukemia (ALL); 2) a 50-year-old male with non-Hodgkin's lymphoma (NHL); 3) a 60-year-old male undergoing heart bypass surgery (CABG); and 4) a 70-year-old female undergoing a hip arthroplasty. Pathogen exposure included HIV, HCV, HBV, HTLV-I, bacterial sepsis and emerging pathogens. The model compared projected quality-adjusted life-year saved (QALY) and costs for patients receiving untreated vs. treated platelets. **RESULTS:** The incremental cost per QALY gained by using RDP + IBS vs. RDP ranged from €386,525–€1,178,187. Corresponding figures for SDP + IBS vs. SDP ranged from €1,082,170–€2,805,297. Inclusion of an emerging pathogen benefit significantly improved the cost effectiveness to €65,423–€307,311 for RDP and €300,793–€1,223,349 for SDP. The model was most sensitive to mortality from bacterial contamination and the number of additional platelet transfusions required due to IBS treatment. The model was relatively insensitive to transmission risks from currently known viruses. **CONCLUSION:** The cost effectiveness of IBS for platelets is comparable to that of other blood safety interventions (e.g., NAT, plasma inactivation) that are accepted as valuable in Spain. Thus, pathogen inactivation with IBS may be considered as a desirable strategy to ensure the safety of platelet transfusions and a valuable insurance against the threat of new emerging pathogens.